DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G160	A. BUILDING _____ B. WING _____	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 07	78 53RD PLACE, SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHDULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A re-certification survey was conducted from 5/17/2011 through 5/20/2011. A random sampling of three clients was selected from a population of five individuals with varying degrees of mental and physical disabilities. This re-certification was initiated utilizing the fundamental survey process, but had to be extended in the Condition of Participation of Health Care due to concerns in nursing practice and oversight. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	W 000	6/22/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated, integrated, and monitored services, for two of the three clients residing in the facility. Clients #1 and #3) The findings include: The facility ' s Qualified Intellectual Disability Professional (QIDP) failed to ensure all staff were effectively trained to serve meals in the texture	W 159	See I 183	6/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Compliance Supervisor 6/24/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 and form prescribed. (See W189, W460 and W474)	W 159		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure all staff were effectively trained to implement each client ' s mealtime feeding protocol for two of three sampled clients. [Clients #1 and #3] The finding includes: [Cross Reference W474] Observation on 5/17/2011 beginning at 4:45 p.m. revealed, Client #1 and Client #3 were served a snack of sliced apples (Granny Smith apple) and a cup of fruit punch. The apples appeared firm and made a crunch when the client bit into it. Review of both client ' s nutritional assessments and physician ' s order on 5/19/2011 at approximately 11:30 a.m., revealed they were both prescribed a " chopped " texture diet. It should be noted, Client #1 was prescribed a " mechanically soft, chopped " texture diet. Further review revealed the staff received training on food texture requirements from the Speech Language Pathologist (SLP) on 4/18/2011. Interview with the facility ' s Qualified Intellectual	W 189	See I 183	6/29/11

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W 189	Continued From page 2 Disability Professional (QIDP) on 5/19/2011, at 3:10 p.m. confirmed, the 4/18/2011 training conducted by the SLP was not effective in light of the deficient practices that took place on the evening of 5/17/2011. The QIDP further indicated she would have to ensure additional staff training to address the problem. The facility failed to ensure all staff was effectively trained to implement Client #1 and #3 ' s mealtime feeding protocol and further failed to make certain clients were provided the correct textured diet.	W 189		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the use of behavior modification medications prescribed to complete medical appointments was incorporated in the Individual Program Plan (IPP) for one of three sampled clients. [Client #1] The finding includes: Observation on the evening of 5/17/2011 revealed, Client #1 was on a psychotropic regimen of 20 mg of Paroxetine HCL (for depression) and 20 mg of Zyprexa (anti-psychotic).	W 312	Client has a desensitisation plan in place that includes use of sedation (i.e. Ativan) to address behavior. See attachment All DPs across the setting have been reviewed to ensure that any use of sedation is documented in the DSP and incorporated in the IPP.	12/7/10 6/6/11

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W 312	Continued From page 3 A review of Client #1 ' s 5/2011 Physician ' s Order Sheets (POS) on 5/20/2010 at 11:59 a.m. revealed, Client #1 also had a standing order for "Lorazepam (Ativan) 2 mg Tablet; 1 tab by mouth 1 hour prior to procedure. " The order goes on to further read " Lorazepam (Ativan) 2 mg Tablet; ½ tab prior to procedure if not sedated. " The Ativan prescription was put into effect on 10/27/2010 to manage his non-compliance with his medical appointments. Additional review of his medical record revealed he was sedated on 10/12/2010 for a cardiology (EEG) assessment and again on 10/18/2010 for a dental appointment. Further record review on 5/20/2011 at approximately 12:05 p.m. revealed there was no evidence his Ativan prescription was being used as part of an integral plan to reduce his agitation/non-compliance with meeting medical appointments. Interview and further record review with the facility ' s licensed practical nurse (LPN) and the Qualified Intellectual Disability Professional (QIDP) on 5/20/2011 at approximately 12:10 p.m. confirmed, there was nothing else in place to address his behavior besides the medications. In addition, the physician ' s orders for the 10/12/2010 and 10/18/2010 sedation's were not on file at the time of survey. The facility failed to ensure the implementation of an integral plan to manage Client #1 ' s inability to complete his medical appointments.	W 312		
W 368	483.460(k)(1) DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 4 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client ' s received their medications as prescribed for two of three sampled clients. [Clients #2 and #3] The finding includes: The facility failed to ensure all medications were administered as prescribed and failed to ensure proper medical oversight of all client ' s medications to ensure health and safety as identified below: 1. Record review on 5/19/2011 at 11:25 a.m. revealed Client #2 was prescribed " Hydralazine HCL 50 mg Tablet; 1 tab by mouth every 8 hours (D/W split noon dose). " Further record review revealed the facility was not maintaining a consistent accounting of the " noon " dosage of this medication at his day treatment program. It should also be noted that Client #2 ' s day treatment program is not an outside service and that the residential services are also governed by the same provider. Interview and record review with the facility ' s Registered Nurse (RN) on 5/19/2011 at 5:17 p.m. confirmed the Hydralazine was not administered at the day program on 6/8/2010, 12/1/2010, 12/27/2010 and 12/28/2010. Additional interview on the same day and time with the RN revealed, Client #2 was absent from the day program on	W 368	Provider has revised internal systems to include monthly reviews of MAR's to ensure timely and accurate medication administration Moving forward, nurses will complete, in monthly notes, an audit of MAR medication administration record to ensure that all procedures are followed accordingly and no medications have been missed. Residential and Day programme. nurse have been re trained on the importance of timely documentation and communication of anticipated absences and gaps in medication administration	6/16/11 6/14/11

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W 368	Continued From page 5 the days in questions due to him either being at home or having to attend a medical appointment. Further interview on the same day at approximately 5:20 p.m. confirmed, the facility also failed to ensure the Hydralazine was administered by the home on the days in question. 2. Record review on 5/19/2011 at 5:00 p.m. revealed Client #3 was prescribed " Carbatrol SA 300mg Capsule, 1 Cap by mouth 3 x a day (D/W split noon dose). " Further record review revealed the facility was not maintaining a consistent accounting of the " noon " dosage of this medication at his day treatment program. It should also be noted that Client #3 ' s day treatment program is not an outside service and that the residential services are also governed by the same provider. Interview and record review with the facility ' s Registered Nurse (RN) on 5/19/2011 at 5:33 p.m. confirmed the Carbatrol was not administered at the day program on 12/8/2010, 12/9/2010, 8/2/2010, 8/3/2010, 8/4/2010, 8/5/2010, 8/6/2010 and 6/28/2010. Additional interview on the same day and time with the RN revealed, Client #2 was absent from the day program on the days in questions due to him either being at home, on vacation or having to attend a medical appointment. Further interview on the same day at approximately 5:38 p.m. confirmed, the facility also failed to ensure the Carbatrol was administered by the home on the days in questions.	W 368		
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 6 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all three shifts took part in evacuation drills over the past three months (quarter) to ensure the health and safety of all clients residing in the facility during emergent situations. [Clients #1, #2, #3, #4 and #5] The finding includes: Review of the fire drill logs on 5/19/2011 at approximately 9:30 a.m. revealed there were no drills on record for the a.m. to 4:30 p.m. shift between the three months period covering 2/2011 to 4/2011. Interview with the Qualified Intellectual Disability Professional (QIDP) on 5/20/2011 at approximately 3:30 p.m. revealed he was following the scheduled fire drill policy which outlines when the drills should be conducted. Upon further inspection, the QIDP confirmed there were no 8:00 a.m.-4:30 p.m. drills scheduled for the three months period covering 2/2011 and 4/2011. The facility failed to ensure fire drills were varied in a manner to ensure evacuation drills were held at least quarterly for each shift.	W 440	Drills are scheduled quarterly pursuant to a calender year. Please find schedule attached.	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441	Fire drill schedule implemented ~~pursuant~~ June 1st 2011 reflects greater variation in scheduling.	6/1/11

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W 441	Continued From page 7 This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure all fire drills were scheduled or implemented under varying conditions to ensure the health and safety of all clients residing in the facility during emergent situations. [Clients #1, #2, #3, #4 and #5] The finding includes: [Cross Reference W440) Interview with the facility's House Manager (HM) on 5/17/2011 at approximately 9:55 a.m., revealed the facility's staffing patterns consisted of three eight hour shifts per day. The shifts were blocked to cover 12 a.m. to 8 a.m., 8 a.m. to 4 p.m., and 4 p.m. to 12 a.m. daily. According to the HM, the same staffing pattern was also mirrored over the weekends. Review of the fire drill logs on 5/19/2011 at approximately 9:35 a.m. revealed the majority of the drills were being conducted at either 12 a.m. or 4:30 p.m. for the months of 2/2011, 3/2011 and 4/2011. In addition, the fire drill logs failed to reflect an accurate usage of egress points over the past twelve months. The fire drill logs that were made available at the time of survey, failed to reflect that either the second floor exit door or the basement exit door was ever used as a point of egress for any drills during the past twelve months. Interview with the Qualified Intellectual Disability Professional (QIDP) on 5/20/2011 at	W 441	In addition staff have been retrained on the correct implementation of varied egress to ~~ensure~~ and documentation of fire drills to ensure varied exits were used during drills.	6/29/11.

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W 441	Continued From page 8 approximately 3:35 p.m. confirmed the fire drill logs that were available at the time of survey failed to reflect varying conditions with regards to time and egress points. The facility failed to ensure the scheduling of fire drills allowed for varying conditions with regards to time and egress points.	W 441		
W 460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure clients received their meals in the manner prescribed for two of three sampled clients. [Clients #1 and #2] The finding includes: The facility failed to ensure all clients received their meals in accordance with their prescribed dietary orders as identified below: 1. Observation on the evening of 5/17/2011 at approximately 6:00 p.m. revealed Client #2 was served a meal of rice, onions, ground beef, a slice of wheat bread, a cup of fruit juice and a bowl of mixed fruit. His serving size was no different than anyone else at the table. Record review on 5/19/2011 at 11:57 a.m. revealed his 5/2011 physician ' s orders prescribed his meals be served, " low	W 460	Staff have been re-trained to ensure proper meal preparation to include texture and form pursuant to individuals dietary orders. 6/20/11 QDDP and HRM will conduct a review every 3 months to ensure that individuals meal plans and dietary specifications are being adhered to.	

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W 460	Continued From page 9	W 460		

cholesterol, no added salt, double portions at dinner time. " This order was put into effect on 12/8/2010. Client #2 was not observed to be offered or provided " double portions " during dinner on the evening of 5/17/2011.

Interview with the facility ' s Registered Nurse (RN) on the same day at approximately 12:05 p.m. confirmed, the " double portions " order was correct and that the staff should have at least offered Client #2 a second serving of his meal.

2. Observation on the evening of 5/17/2011 at approximately 5:00 p.m. revealed the staff preparing the meal seasoned the meat and the cooking sauces prior to placing them on the stove. The smell of the seasoning was very aromatic and filled the home as the staff prepared the meal. Further observations on the same day 6:05 p.m. revealed Client #3 was served a portion of rice, sautéed onions, ground beef, a slice of wheat bread, a cup of fruit juice and a bowl of mixed fruit. Neither the serving size nor the content of the meal was any different than anyone else ' s at the table.

Record review on 5/19/2011 at 10:57 a.m. revealed his 5/2011 physician ' s orders prescribed his meals be served, " low sodium, low fat, bland and high fiber, chopped diet. " This order was put into effect on 4/6/2011. Client #3 was not observed to be offered or provided " a bland diet " during dinner on the evening of 5/17/2011.

Interview with the facility ' s Registered Nurse (RN) on the same day at approximately 12:05 p.m. confirmed, the " bland diet " order was

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W 460	Continued From page 10 correct and that the staff should have ensured Client #3 received a bland meal.	W 460		
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure client ' s received their meals in the form and texture prescribed for one of two sampled clients. [Clients #1 and #3] The finding includes: Observation on 5/17/2011 at 4:45 p.m. revealed, Client #1 and #3 were served a snack of sliced apples (Granny Smith apple) and a cup of fruit punch. The apples appeared firm and made a crunch when the client bit into it. Review of Client #1 ' s nutritional assessment and 5/2011 physician ' s order sheets (POS) on 5/12/2011 at 4:27 p.m. revealed he was prescribed a " mechanically soft ... chopped " texture diet. Review of Client #3 ' s 5/2011 physician ' s order sheets on 5/19/2011 at 11:06 a.m. revealed he was prescribed a " chopped " texture diet. Interview with the facility ' s Qualified Intellectual Disability Professional (QIDP) and the Registered Nurse (RN) on 5/19/2011, at approximately 12:05 p.m. confirmed, the " chopped " texture order was correct and that the staff should have ensured both Clients #1 and #3 received the	W 474	Staff have been retrained per W460	6/2/11

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W 474	Continued From page 11 apples in a chopped texture. The facility failed to ensure all clients received their meals in the prescribed texture requirement to ensure their health and safety during meals.	W 474		

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS A re-licensure survey was conducted from 5/17/2011 through 5/20/2011. A random sampling of three residents was selected from a population of five individuals with varying degrees of mental and physical disabilities. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	I 000		
I 183	3508.4 ADMINISTRATIVE SUPPORT Each GHMRP shall have a Residence Director who meets the requirements of § 3509.1 and who shall manage the GHMRP in accordance with approved policies and this chapter. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the Qualified Intellectual Disability Professional (QIDP) coordinated, integrated, and monitored services, for two of the three sampled residents. (Residents #1 and #3) The findings include: The facility ' s Qualified Intellectual Disability Professional (QIDP) failed to ensure all staff were effectively trained to serve meals in the texture and form prescribed. (See Federal Deficiency Citations W189, W460 and W474)	I 183	Staff have been retrained 6/20/11 to ensure proper implementation of meal preparation to include texture and form pursuant to individual dietary orders. Periodic training implemented to ensure dietary requirements are being adhered to. Scheduled for every 3mths. see attached.	
I 229	3510.5(f) STAFF TRAINING	I 229		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 229	Continued From page 1 Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, staff interview and record review, Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure all staff was effectively trained to provide resident ' s their meals in the manner prescribed by the primary care physician for two of three sampled residents. [Residents #1 and #3] The findings include: The facility failed to ensure all residents received their meals in accordance with their prescribed dietary orders as identified below: 1. Observation on the evening of 5/17/2011 at approximately 6:00 p.m. revealed Resident #2 was served a meal of rice, onions, ground beef, a slice of wheat bread, a cup of fruit juice and a bowl of mixed fruit. His serving size was no different than anyone else at the table. Record review on 5/19/2011 at 11:57 a.m. revealed his 5/2011 physician ' s orders prescribed his meals be served, " low cholesterol, no added salt, double portions at dinner time. " This order was put into effect on 12/8/2010. Resident #2 was not observed to be offered or provided " double portions " during dinner on the evening of 5/17/2011.	I 229	See I 183	6/29/11

Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0147	A. BUILDING _____ B. WING _____	05/20/2011

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I 229	Continued From page 2	I 229		

Interview with the facility ' s Registered Nurse (RN) on the same day at approximately 12:05 p.m. confirmed, the " double portions " order was correct and that the staff should have at least offered Resident #2 a second serving of his meal.

2. Observation on the evening of 5/17/2011 at approximately 5:00 p.m. revealed the staff preparing the meal seasoned the meat and the cooking sauces prior to placing them on the stove. The smell of the seasoning was very aromatic and filled the home as the staff prepared the meal. Further observations on the same day 6:05 p.m. revealed Resident #3 was served a portion of rice, sautéed onions, ground beef, a slice of wheat bread, a cup of fruit juice and a bowl of mixed fruit. Neither the serving size nor the content of the meal was any different than anyone else ' s at the table.

Record review on 5/19/2011 at 10:57 a.m. revealed his 5/2011 physician ' s orders prescribed his meals be served, " low sodium, low fat, bland and high fiber, chopped diet. " This order was put into effect on 4/6/2011. Resident #3 was not observed to be offered or provided " a bland diet " during dinner on the evening of 5/17/2011.

Interview with the facility ' s Registered Nurse (RN) on the same day at approximately 12:05 p.m. confirmed, the " bland diet " order was correct and that the staff should have ensured Resident #3 received a bland meal.

3. Observation on 5/17/2011 at 4:45 p.m. revealed, Resident #1 and #3 were served a snack of sliced apples (Granny Smith apple) and a cup of fruit punch. The apples appeared firm

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I 229	Continued From page 3 and made a crunch when the resident bit into it. Review of Resident #1 ' s nutritional assessment and 5/2011 physician ' s order sheets (POS) on 5/12/2011 at 4:27 p.m. revealed he was prescribed a " mechanically soft ... chopped " texture diet. Review of Resident #3 ' s 5/2011 physician ' s order sheets on 5/19/2011 at 11:06 a.m. revealed he was prescribed a " chopped " texture diet. Interview with the facility ' s Qualified Intellectual Disability Professional (QIDP) and the Registered Nurse (RN) on 5/19/2011, at approximately 12:05 p.m. confirmed, the " chopped " texture order was correct and that the staff should have ensured both Residents #1 and #3 received the apples in a chopped texture. The facility failed to ensure all residents received their meals in the prescribed texture requirement to ensure their health and safety during meals.	I 229		

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R 000	INITIAL COMMENTS A re-licensure survey was conducted from 5/17/2011 through 5/20/2011. A random sampling of three residents was selected from a population of five individuals with varying degrees of mental and physical disabilities. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to provide evidence that criminal background checks covered the seven year work and residence history of each staff prior to their start of employment for two (2) out of thirteen (13) staff. [Staffs #1 and #2] The finding includes: Record review and interview with the GHPID's Qualified Intellectual Disability Professional (QIDP) on 5/19/2011, at approximately 4:30 p.m., confirmed the following deficient practices: 1. Staff #1's records reflect they either lived or	R 125		

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R 125	Continued From page 1 worked in the state of Pennsylvania within the seven years prior to the screening, but the criminal background check only covered the state of Maryland. 2. Staff #2's records reflect they either lived or worked in the state of North Carolina within the seven years prior to the screening, but the criminal background check only covered the state of the District of Columbia and the state of Maryland.	R 125	1. Background Screening was conducted on staff # 1 including PA. Results were on a separate sheet included in personnel folders. See attachments 2. Record review does not show any staff on schedule that lived or worked in North Carolina over the past 7 years. * Please note, Screening for staff #1 was completed prior to Survey date of 5/20 and inserted in personnel folders 5/16/11 per our revised QA procedures	5/16/11 5/16/11 5/16/11